

COMPLAINT FORM

Information required therein will assist OHR staff to determine the nature and extent of discrimination as defined by the Federal/Local Discrimination Laws. Please complete the following form in its entirety and to the best of your knowledge. This form is subject to review and acceptance by the Office of Human Rights.

Notice of Non-Discrimination

In accordance with the D.C. Human Rights Act of 1977, as amended, D.C. Official Code Section 2-1401.01 et seq., (Act) the District of Columbia does not discriminate on the bases of actual or perceived: race, color, religion, national origin, sex, age, marital status, personal appearance, sexual orientation, familiar status, family responsibilities, matriculation, political affiliation, disability, source of income, or place of residence or business. Sexual harassment is a form of sex discrimination, which is also prohibited by the Act. In addition, harassment based on any of the above-protected categories is also prohibited by the Act. Discrimination in violation of the Act will not be tolerated. Violators will be subject to disciplinary action.

1. COMPLAINANT	
Date:	OHR Docket No.: EEOC No.:
Name:	
Address:	
City/State/Zip:	
Tel # (H):	Tel # (W):
Race: _____	Social Security No.: _____
Sex: _____	Date of Birth: _____
CONTACT PERSON IF YOU CANNOT BE REACHED:	
Name:	
Address:	
City/State/Zip:	
Tel # (H):	Tel # (W):

IF REPRESENTED BY COUNSEL, PLEASE PROVIDE THE FOLLOWING:**Name:** _____ **Telephone/Fax:** _____**Address:** _____

*Please note: If you are represented by counsel or retain counsel prior to your scheduled Intake interview, the counsel must either (1) be present with you for the duration of your Intake interview, or (2) withdraw his/her appearance from the interview by submitting a letter to the Office indicating that the interview may take place without his/her representation.

2. RESPONDENT**Name of company or organization:****Name and Title of principal officer (i.e. President, Owner, Human Resources Manager):****Nature of Business:****Address:****City/State/Zip:****Tel #:****Fax #:****3. BASIS OF COMPLAINT****The basis is the reason you were treated differently than others outside of your protected class.****Do you feel you were discriminated against because of your: (Please check appropriate box and provide detail, if necessary.)**

- | | |
|--|---|
| <input type="checkbox"/> Race _____ | <input type="checkbox"/> Sex _____ |
| <input type="checkbox"/> National Origin _____ | <input type="checkbox"/> Religion _____ |
| <input type="checkbox"/> Color _____ | <input type="checkbox"/> Age _____ |
| <input type="checkbox"/> Disability _____ | <input type="checkbox"/> Familial Status <input type="checkbox"/> Source of Income |
| <input type="checkbox"/> Matriculation <input type="checkbox"/> Marital Status | <input type="checkbox"/> Personal Appearance <input type="checkbox"/> Sexual Orientation |
| <input type="checkbox"/> Place of Residence or Business | <input type="checkbox"/> Political Affiliation <input type="checkbox"/> Family Responsibilities |

* Please note: Pursuant to the D.C Human Rights Act of 1977, as amended, the “familial status” and “source of income” bases are applicable only when alleging discrimination in housing, public accommodations and educational institutions. The basis of “place of residence or business” is applicable only if alleging discrimination in housing.

4. JURISDICTION

- ☐ Alleged violation occurred in the District of Columbia.
- ☐ Alleged violation occurred 365 days or less (6 months or less for D.C. Government Employees).
- ☐ At least 1 employee (More than 15 employees to cross file with EEOC).
- ☐ You have not commenced any other action, civil, criminal, or administrative in any other forum based on the same unlawful discriminatory practice described herein.

5. AREA OF COMPLAINT

- ☐ Employment ☐ Public Accommodation ☐ Educational Institution
- ☐ DC Family and Medical Leave Act

6. ISSUES

What action was taken that made you feel you were treated differently?

- ☐ Family Medical Leave ☐ Promotion ☐ Transfer ☐ Demotion ☐ Discharge
- ☐ Retaliation ☐ Sexual Harassment ☐ Hostile Work Environment ☐ Failure to Hire
- ☐ Equal Pay ☐ Terms and Conditions ☐ Failure to Accommodate ☐ Discipline
- ☐ Denial of Service ☐ Constructive Discharge ☐ Admission or Admission Fees ☐ Discounts
- ☐ Crowd Capacity ☐ Personal Identification ☐ Time of day/event ☐ Restrictions/Rules
- ☐ Credit/Insurance ☐ Complimentary Admission/Guest ☐ Curriculum
- ☐ Membership Fee/Dues ☐ Program Participation

Other: _____

7. DISTRICT OF COLUMBIA GOVERNMENT EMPLOYEES OR APPLICANTS

***Please note: Pursuant to §105 of DCMR Title IV, all District Government employees must first consult an agency EEO counselor within 180 days of the alleged discriminatory act prior to filing with the Office of Human Rights, *unless* the District Government employee is alleging unlawful discrimination based on sexual harassment. The Office of Human Rights cannot process a complaint from a current or former District Government employee unless (1) the employee has received an exit letter from his/her agency EEO Counselor; (2) twenty-one days have passed since the matter was called to the attention of the agency's EEO counselor and no exit letter has been written; or (3) the employee is alleging unlawful discrimination**

based on sexual harassment.

- ☐ You have filed an informal complaint with an agency assigned EEO Officer/ Counselor.

Counselor's Name: _____

Counselor's Agency: _____

Counselor's Telephone Number: _____

Date Filed: _____ Date of Exit Letter: _____

8. EMPLOYMENT

Time of Hire, Evaluations, Discipline, Termination

Date of Hire: _____ Title: _____

Salary at time of hire: _____

Date of Last Performance Evaluation: _____

Supervisor/Manager who performed the Evaluation: _____

Last Performance Evaluation Rating : ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Alleged adverse actions taken against you (i.e., written reprimand, suspension, denial of promotion) and the date the action was taken:

Action: _____ Date: _____

Action: _____ Date: _____

- ☐ **Current** or ☐ **Final** position held with Respondent: _____

Salary: _____

What reason did Respondent give for your ☐ **termination** or ☐ **denial of promotion**:

☐ Work Performance ☐ Attendance ☐ Insubordination ☐ Gross Misconduct

Date of Termination/Denial of Promotion: _____

9. PUBLIC ACCOMMODATION/EDUCATIONAL INSTITUTIONS

(Only complete section if your complaint deals with discrimination against a public accommodation or educational institution.)

Date of alleged incident: _____

Service you requested: _____

Person who denied your service request:

Name: _____ Title: _____

How is this person different from you (i.e. what is this person's protected basis?):

Have you tried to resolve this matter with the Respondent? If so, please describe with whom you spoke and their response:

10. D.C. FAMILY AND MEDICAL LEAVE ACT

(Only complete section if your complaint deals with FMLA.)

Have you been employed with this company for at least one (1) year and have worked at least one thousand (1,000) hours?
☐ **YES** ☐ **NO**

Date(s) you requested: _____

Reason you requested: _____

Person who denied your request: _____

Title: _____

Others who have requested leave: _____

How are these persons different from you: _____

Have you tried to resolve this matter with Respondent? If so, please describe with whom you spoke and their response:

Name/Title: _____

11. WITNESSES

List whom you feel can corroborate your experience and provide evidence in your support.

Name: _____

Title: _____

Telephone: _____

What s/he can attest to: _____

Name: _____

Title: _____

Telephone: _____

What s/he can attest to: _____

Name: _____

Title: _____

Telephone: _____

What s/he can attest to: _____

Name: _____

Title: _____

Telephone: _____

What s/he can attest to: _____

12. YOUR COMPLAINT

Describe in detail the incident(s) that led you to file a complaint of discrimination. Please list dates as well as the name(s) of the person(s) who discriminated against you in denying employment, promotion, training, goods, services, educational services, etc. If this is a disability-based complaint, please specify whether an accommodation was requested; the person the request was submitted to and the date Respondent was notified of your disability.

The D.C. Office of Human Rights provides mediation. Mediation is a process in which an acceptable, impartial, third party attempts to assist disputing parties toward a mutual settlement. Two (2) mediators (co-mediators) are assigned to each case as a neutral third party to assist disputants in reaching a mutually acceptable resolution to their problem(s). The mediation process is mandatory and disputing parties design solutions to their own problems.

Please Note: In the event the Investigation reveals that your complaint should be dismissed you will receive a letter explaining the reasons for dismissal. Applicable regulations also require the OHR to send a copy of the dismissal notice to the Respondent.

Complainant's Signature

Date

NOTARY SECTION

I, _____, having read the above, state that the responses contained herein are true and correct to the best of my knowledge and belief.

Signature

SUBSCRIBED AND SWORN to before me this _____ day of _____, of 20____.

Notary Signature

My Commission Expires: _____.

FOR OFFICE USE ONLY: JURISDICTION

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